



Arizona Department of Health Services
Division of Licensing Services
Long Term Care Licensing

Confidential File
Date: _____
Init: _____

150 N. 18th Ave., Ste. 440
Phoenix, AZ 85007
Phone: (602) 364-2690
After Hours: (602) 364-2677
Fax: (602) 364-4765

400 W. Congress, Ste. 116
Tucson, AZ 85701
Phone: (520) 628-6965
After Hours: (520) 628-6973
Fax: (520) 628-6991

REPORTABLE EVENT RECORD/REPORT

Please answer all questions fully and address only one event per report
Submit via Fax within 5 days of event

Today's Date (mm/dd/yyyy)		Date of Event (mm/dd/yyyy)		Time of Event <input type="checkbox"/> AM <input type="checkbox"/> PM	
Was this a significant event? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was significant event called in? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date (mm/dd/yyyy)	
				Time <input type="checkbox"/> AM <input type="checkbox"/> PM	

Full Name of Facility

Street Address

City	State	Zip Code
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Facility Telephone Number	Facility License Number	Provider ID Number
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Person Reporting	Title
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Type of Incident:	
<input type="checkbox"/> Elopement <input type="checkbox"/> Environmental Emergency <input type="checkbox"/> Financial Exploitation <input type="checkbox"/> Injury <input type="checkbox"/> Incident <input type="checkbox"/> Involuntary Discharge <input type="checkbox"/> Other, Specify:	<input type="checkbox"/> Injury Unknown Origin <input type="checkbox"/> Neglect <input type="checkbox"/> Resident Care <input type="checkbox"/> Resident-to-Resident Abuse <input type="checkbox"/> Staff-to-Resident Abuse <input type="checkbox"/> Unexpected Death

Who was notified of the occurrence?			
<input type="checkbox"/> Law Enforcement	Police Dept. Name	Case Number	Officer

<input type="checkbox"/> Nursing Board	<input type="checkbox"/> Medical Examiners	<input type="checkbox"/> Pharmacy Board	<input type="checkbox"/> Physician	<input type="checkbox"/> Ombudsman	<input type="checkbox"/> APS
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<input type="checkbox"/> Family/Guardian	<input type="checkbox"/> Other
<input type="checkbox"/> Pool Agency (Name and Phone Number)	

REPORTABLE EVENT RECORD/REPORT
(Continued)

Resident Name	Date of Admission	Date of Birth
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Exact Location of Incident:

Narrative:

1) Describe the event, including timeframes/risk factors related to the incident/event (relevant resident dx and cognitive status)

2) Prior to the event, was a plan of care developed that addressed this issue, and were planned interventions in place when the event occurred? For example, a chair alarm or a lap buddy in place.

☐ Yes ☐ No Please describe:

3) What interventions were implemented after the incident/event? For example, supervision, resident sent to hospital, CNA suspended. Please describe investigative findings/conclusions:

REPORTABLE EVENT RECORD/REPORT
(Continued)

Is the event an allegation of abuse, neglect or misappropriation of funds? If yes, complete the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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ALLEGED PERPETRATOR INFORMATION			
Name:			
Last	First	MI	Alias

Address:			
Street/Box	City	State	Zip

Telephone Number:	Date of Hire:

AP Suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	AP Terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:

CREDENTIALING/LICENSE INFORMATION	
Certificate or License No.	
Type of Certification (check all that apply)	
<input type="checkbox"/> Nurse Aid (NA)	<input type="checkbox"/> Certified Nurse Aid (CNA)
<input type="checkbox"/> Registered Nurse (RN)	<input type="checkbox"/> Licensed Practical Nurse (LPN)
<input type="checkbox"/> Other (specify type:)	

FOR ADHS USE ONLY

Reviewed By	Date	AZ Intake #
Second Reviewer	Date	Date Report Received:

Disposition:	<input type="checkbox"/> Complaint Investigation	<input type="checkbox"/> No Action	<input type="checkbox"/> Pending	<input type="checkbox"/> Offsite Investigation
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<input type="checkbox"/> Referral, specify:	

<input type="checkbox"/> Closed, specify date closed:	

Comments:	

REPORTABLE EVENT RECORD/REPORT
(Continued)

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, And Exploitation
of Residents in Long-Term Care Facilities

Use Separate sheet for each witness/person interviewed

Witness Statement Form		
Date:	Time:	<input type="checkbox"/> AM <input type="checkbox"/> PM
Witness Full Name:		
Job Title:	Shift:	
Home Address:	City/Zip	
Home Phone #:	Work Phone #:	
Relation to Resident: (If any)		

State in your own words what you witnessed (be very descriptive) and sign below.

The information provided above is true to the best of my knowledge.

Signature of Witness	Date
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